

¹ 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On April 14, 2005 appellant, then a 39-year-old medical support assistant, filed an occupational disease claim (Form CA-2) alleging that on March 10, 2005 she first realized that her strain, pain, swelling, and carpal tunnel of both wrists, worse on the left, were caused by her federal employment. In an undated letter, she attributed her wrist and hand conditions to her repetitive work duties. Medical reports dated March 10, 2005 provided findings on examination of appellant's bilateral forearms, wrists, and hands and diagnosed bilateral forearm, hand, and wrist strain and pain. On July 8, 2005 OWCP accepted the claim for bilateral hand strain and sprain/strain of an unspecified site of the bilateral forearms.

On August 29, 2005 appellant returned to her regular duties four hours a day. On September 2, 2005 the employing establishment offered her a full-time modified limited-duty job that she accepted on the same date. On November 8, 2005 appellant stopped work.

On November 17, 29, and 30, 2005 appellant filed claims for compensation (Forms CA-7) for leave without pay from November 8 to December 29, 2005. In a January 31, 2006 decision, OWCP denied her claim for a recurrence of disability commencing November 8, 2005. It found that the medical evidence established that appellant was capable of performing her regular duties eight hours a day with necessary ergonomic equipment.²

On February 14, 2006 OWCP received a January 13, 2006 report from Dr. Jeffrey L. Gao, an attending physician Board-certified in occupational medicine. Dr. Gao noted a history of injury and appellant's medical treatment. He provided findings on physical examination which included range of motion measurements for the right wrist. Dr. Gao diagnosed mild right wrist carpal tunnel syndrome. He determined that appellant had 20 percent impairment of the right upper extremity and an additional 3 percent impairment for loss of grip strength and pain based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). Dr. Gao concluded that she had reached maximum medical improvement (MMI) on the date of his examination.

On September 20, 2008 appellant filed a Form CA-7 for a schedule award. On the same date, OWCP referred the case to an OWCP medical adviser. A statement of accepted facts (SOAF) indicated that it had also accepted appellant's claim for right carpal tunnel syndrome.

In a September 20, 2008 report, an OWCP medical adviser applied the fifth edition of the A.M.A., *Guides* to Dr. Gao's January 13, 2006 findings and determined that appellant had 17 percent impairment of the right upper extremity and no impairment of the left upper extremity. He further determined that she was not entitled to additional impairment for loss of grip strength and pain. The medical adviser concluded that appellant reached MMI on January 13, 2006, the date of Dr. Gao's evaluation.

² Appellant requested reconsideration of the January 31, 2006 denial of her recurrence claim. In a September 8, 2006 decision, OWCP denied modification of the January 31, 2006 decision. It found that the medical evidence was insufficient to establish that appellant sustained a recurrence of total disability commencing November 8, 2005.

By decision dated October 21, 2008, OWCP granted appellant a schedule award for 17 percent permanent impairment of the right arm and found that she had no impairment of the left arm based on the opinion of its medical adviser.

On January 28, 2011 appellant underwent authorized right open carpal tunnel release performed by Dr. Robert A. Gomez, an attending Board-certified orthopedic surgeon. On April 1, 2011 Dr. Gomez performed authorized left open carpal tunnel release. On October 7, 2011 he performed authorized left elbow ulnar nerve release and medial epicondylectomy.

On December 15, 2011 appellant filed a Form CA-7 for an additional schedule award.

By letter dated December 29, 2011, OWCP requested a medical opinion from her physician assessing her permanent impairment based on the sixth edition of the A.M.A., *Guides* and establishing that she had reached MMI.

In a January 4, 2012 letter and treatment note, Dr. Gomez indicated that he was not familiar with the sixth edition of the A.M.A., *Guides* and that he used the fifth edition of the A.M.A., *Guides*, as required in California. He noted that in November 2011 he had injected the right radial tunnel and appellant had partial relief from forearm discomfort. Dr. Gomez advised that it was not a good time to have either extremity evaluated since she recently had left elbow surgery and was overusing her right upper extremity. He recommended an impairment evaluation by someone familiar with the sixth edition of the A.M.A. *Guides* after appellant's left elbow settled down in three or four months.

On February 2, 2012 OWCP advised appellant that it would refer her for a second opinion examination regarding permanent impairment due to her accepted work injury. In a SOAF prepared on January 30, 2012, it advised that it had accepted the claim for bilateral hand sprain, bilateral medial epicondylitis, bilateral forearm sprain, and bilateral carpal tunnel syndrome.

By letter dated February 9, 2012, OWCP notified appellant that she was scheduled for a March 8, 2012 appointment for a second opinion with Dr. Mohinder S. Nijjar, a Board-certified orthopedic surgeon.

In a March 15, 2012 report, Dr. Nijjar noted that he had evaluated appellant on March 8, 2012. He provided a history of injury and appellant's medical and employment background and reviewed medical records. Dr. Nijjar provided examination findings and diagnosed left medial epicondylitis, status post medial epicondylectomy and decompression of the ulnar nerve, median nerve entrapment, and status post decompression at the right and left wrists. He found that appellant had 2 percent impairment of the right arm and 11 percent impairment of the left arm³ based on the sixth edition of the A.M.A., *Guides*. Dr. Nijjar found that she reached MMI on the date of his examination.

³ Dr. Nijjar found five percent impairment due to medial epicondylitis and six percent due to median and ulnar nerve impairment.

On June 25, 2012 a second OWCP medical adviser reviewed the medical record, including Dr. Nijjar's March 15, 2012 findings, and agreed that appellant had 2 percent impairment of the right upper extremity and 11 percent impairment of the left upper extremity under the sixth edition of the A.M.A., *Guides*. He found that she reached MMI on March 15, 2012, the date of Dr. Nijjar's report.

In an August 21, 2012 decision, OWCP found that appellant had no more than the previously awarded 17 percent permanent impairment of the right upper extremity and granted her a schedule award for 11 percent permanent impairment of the left upper extremity based on the opinions of Dr. Nijjar and its second medical adviser.

On December 27, 2013 Dr. Gomez performed authorized right elbow in situ ulnar nerve release. In a February 3, 2014 report, he noted that appellant's numbness and pain had significantly improved following this surgery. Dr. Gomez advised appellant to perform desensitization and mobilization exercises since her scar was very tender. He concluded that appellant would remain off work until her next evaluation in one month.

On January 5, 2015 appellant filed a Form CA-7 for an additional schedule award.⁴

By letter dated January 15, 2015, OWCP notified appellant of the deficiencies of her claim. It afforded her 30 days to submit additional evidence, including a medical report containing a detailed description of her permanent impairment based on the sixth edition of the A.M.A., *Guides*.

Appellant did not respond. In a February 18, 2015 decision, OWCP denied her claim for an additional schedule award.

On March 3, 2015 appellant requested reconsideration of the February 18, 2015 decision. In a March 11, 2015 letter, she requested a referral to a physician who utilized the sixth edition of the A.M.A., *Guides* as recommended by Dr. Gomez in his February 9, 2015 treatment note.

By letter dated April 17, 2015, OWCP notified appellant that she was scheduled for a May 8, 2015 appointment for a second opinion with Dr. Bruce E. Thompson, a physician Board-certified in occupational medicine.

In a May 8, 2015 report, Dr. Thompson noted a history of appellant's occupational, medical, social, and family background. He indicated that she had retired on July 2, 2006. Dr. Thompson reviewed medical records and the SOAF. On examination of the arms, he found well-healed surgical scars at the cubital and carpal tunnel consistent with appellant's past history of four surgeries. There was a slight decrease in sensation to simple monofilament. Deep tendon reflexes were brisk and equilateral at the bicep, triceps, and brachioradialis. A Jamar dynamometer revealed 65, 60, and 60 pounds on the left and 65, 70, and 65 pounds on the right. Range of motion of the shoulders, elbows, and wrists were equilaterally normal in all planes.

⁴ Appellant previously filed a Form CA-7 on March 11, 2014 for an additional schedule award. By letter dated March 28, 2014, OWCP advised her that no action would be taken on her claim as Dr. Gomez's February 3, 2014 report indicated that she had not yet reached MMI.

Motor strength in flexion, extension, supination, and pronation against resistance were equal on the left side to the right side at level 5/5. Circumferential measurements for the right and left mid-arm were each 11.5 inches and the right and left mid forearm were each 11.0 inches. Two-point discrimination of 0.2 centimeters was over the palmar surface of all ten fingertips. Sensory deficit in the median and ulnar nerve distribution was mild to moderate as tested by monofilament and light brush and touch with preserved sharp and dull discrimination. Deep tendon reflexes were brisk and equilateral at the biceps, triceps, and brachioradialis. Finklestein's test was negative. Dr. Thompson diagnosed bilateral carpal tunnel syndrome status postsurgical release and bilateral cubital tunnel syndrome status postsurgical release. He noted that, since appellant had retired, she continued to be able to perform all activities of daily living. Appellant generally had a good result from her four surgeries, noting the last surgery was in December 2013 to release compression of both ulnar and radial nerves. Dr. Thompson advised that appellant reached MMI in all four areas on December 1, 2014.

In rating impairment under the sixth edition of the A.M.A., *Guides*, Dr. Thompson noted his diagnoses of bilateral cubital tunnel syndrome and bilateral carpal tunnel syndrome were essentially an identical manifestation without significant difference in the four nerves, as evaluated by functional history, physical examination, and clinical studies on both the left and right. He found that appellant's functional history revealed mild intermittent paresthesias and mild ache and pain about the bilateral wrist and elbow and mild recurrent numbness in the median and ulnar nerve distribution. Examination showed bilateral full range of motion of the elbows, wrists, and hands and mild ulnar nerve decreased sensitivity in the distal dermatomes. Clinical Studies included a May 25, 2010 electromyogram/nerve conduction studies (EMG/NCS) which revealed right median nerve compression at the carpal tunnel. There was borderline slowing motor conduction of the left ulnar nerve across the carpal tunnel (cubital tunnel syndrome). There was also normal conduction velocity across the canal of the Guyon. Dr. Thompson indicated that all four nerves, right medial nerve, right ulnar nerve, left medial nerve, and left ulnar nerve, were rated in the same class and grade. He determined that appellant had two percent impairment of the right arm due to residual problems status post carpal tunnel release under Table 15-23 on page 449. Dr. Thompson noted that patients with multiple neuropathies the second or smaller nerve impairment was rated at 50 percent of the impairment listed in Table 15-23. He found that appellant had one percent impairment of the right arm due to residual problems, cubital tunnel symptoms status post cubital tunnel release under Table 15-4 on page 399. Dr. Thompson added the two percent impairment rating for carpal tunnel syndrome and one percent impairment rating for cubital tunnel syndrome to calculate three percent impairment of the right arm. Regarding the left arm, he found that appellant had two percent impairment for carpal tunnel syndrome and one percent impairment for cubital tunnel syndrome. Dr. Thompson added these ratings to calculate three percent impairment of the left arm. He found that appellant had three percent impairment of each arm.

On July 8, 2015 a third OWCP medical adviser reviewed Dr. Thompson's May 8, 2015 findings and agreed that appellant had three percent impairment of each upper extremity based on the sixth edition of the A.M.A., *Guides*. She noted that impairment due to bilateral carpal tunnel syndrome was determined by Table 15-23 on page 449. The medical adviser assigned a grade modifier of 1 each for history, physical findings, and test findings. She determined that the average grade modifier was 1. Using the functional scale value of 1, mild, as a modifier, resulted in two percent upper extremity impairment. The medical adviser noted that impairment due to

bilateral cubital tunnel syndrome was also determined by Table 15-23. She assigned a grade modifier of 1 each for history, physical findings, and test findings. The average grade modifier was 1. Using the functional scale value of 1, mild, as a modifier, the medical adviser determined that the upper extremity impairment was two percent. She noted that the second entrapment neuropathy was taken at one-half the value or one percent. The medical adviser found that appellant had a total three percent impairment of each arm. There was no additional impairment for either arm. The medical adviser concluded that appellant had reached MMI on May 8, 2015, the date of Dr. Thompson's examination.

In a July 13, 2015 decision, OWCP denied modification of the February 18, 2015 decision. It found that the weight of the medical evidence rested with the opinions of Dr. Thompson and its medical adviser who determined that appellant had no greater impairment of either upper extremity than previously awarded.

LEGAL PRECEDENT

The schedule award provision of FECA⁵ and its implementing federal regulations⁶ set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.⁷ As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to rate permanent impairment.⁸

The A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF). For upper and lower extremity impairments, the evaluator identifies the impairment class for the Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).⁹ Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.¹⁰

Impairment due to carpal tunnel syndrome is evaluated under the process found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text in

⁵ 5 U.S.C. § 8107.

⁶ 20 C.F.R. § 10.404.

⁷ *Id.* at § 10.404(a).

⁸ See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); see also Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

⁹ *R.Z.*, Docket No. 10-1915 (issued May 19, 2011).

¹⁰ *J.W.*, Docket No. 11-289 (issued September 12, 2011).

section 15.4f of the A.M.A., *Guides*.¹¹ In Table 15-23, grade modifier levels (ranging from 0 to 4) are described for the categories of test findings, history, and physical findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities.¹²

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.¹³

OWCP procedures state that any previous impairment to the member under consideration is included in calculating the percentage of loss, except when the prior impairment is due to a previous work-related injury, in which case the percentage already paid is subtracted from the total percentage of impairment.¹⁴

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish more than 17 percent permanent impairment of the right arm and 11 percent impairment of the left arm.

OWCP accepted appellant's claim for bilateral hand sprain, bilateral medial epicondylitis, bilateral forearm sprain, and bilateral carpal tunnel syndrome. Appellant underwent authorized right open carpal tunnel release on January 28, 2011, left open carpal tunnel release on April 1, 2011, left elbow ulnar nerve release and medial epicondylectomy on October 7, 2011, and right elbow in situ ulnar nerve release on December 27, 2013.

On October 21, 2008 OWCP granted appellant a schedule award for 17 percent impairment of the right upper extremity. On August 21, 2012 it granted her a schedule award for 11 percent impairment of the left upper extremity. On July 13, 2015 OWCP denied modification of its February 18, 2015 denial of appellant's claim for an additional schedule award based on the May 8, 2015 medical opinion of Dr. Thompson, a second opinion physician.

In a May 8, 2015 report, Dr. Thompson, using the sixth edition of the A.M.A., *Guides*, found three percent impairment of each upper extremity due to appellant's bilateral carpal tunnel syndrome status postsurgical release and bilateral cubital tunnel syndrome status postsurgical release. In calculating impairment for appellant's bilateral carpal tunnel syndrome, he properly referenced Table 15-23, Entrapment/Compression Neuropathy Impairment, page 449 of the A.M.A., *Guides*. Dr. Thompson noted that appellant's functional history indicated mild intermittent paresthesias and mild ache and pain about the bilateral wrist and elbow and mild

¹¹ A.M.A., *Guides* 433-50.

¹² *Id.* at 448-50.

¹³ See Federal (FECA) Procedure Manual, *supra* note 8 at Chapter 2.808.6(f) (February 2013).

¹⁴ *Id.* at Chapter 2.808.7.a(2) (February 2013).

recurrent numbness in the median and ulnar nerve distribution. His examination revealed bilateral full range of motion of the elbows, wrists, and hands and mild ulnar nerve decreased sensitivity in the distal dermatomes. Clinical studies included a May 25, 2010 EMG/NCS which demonstrated right median nerve compression at the carpal tunnel, borderline slowing motor conduction of the left ulnar nerve across the carpal tunnel (cubital tunnel syndrome), and normal conduction velocity across the canal of the Guyon. Dr. Thompson related that all four nerves, right medial nerve, right ulnar nerve, left medial nerve, and left ulnar nerve, were rated in the same class and grade. He properly calculated that appellant had two percent impairment of the right arm for residual problems status post carpal tunnel release under Table 15-23. Dr. Thompson noted that patients with multiple neuropathies the second or smaller nerve impairment was rated at 50 percent of the impairment listed in Table 15-23. He found that appellant had one percent impairment of the right arm due to residual problems, cubital tunnel symptoms status post cubital tunnel release, under Table 15-4 on page 399. Dr. Thompson added the two percent impairment rating for bilateral carpal tunnel syndrome and one percent impairment rating for bilateral cubital tunnel syndrome to calculate three percent impairment of the right arm. Regarding the left arm, he also properly found that appellant had two percent impairment for carpal tunnel syndrome and one percent impairment for cubital tunnel syndrome. Dr. Thompson accurately added these impairment ratings to calculate three percent impairment of the left arm. He concluded that appellant had three percent impairment of each arm.

In accordance with its procedures,¹⁵ OWCP properly referred the file to its medical adviser. On July 8, 2015 she advised that the date of MMI was May 8, 2015, the date of Dr. Thompson's evaluation. The medical adviser agreed with Dr. Thompson's assessment that appellant had three percent impairment of each arm. For bilateral carpal tunnel syndrome, she determined under Table 15-23 that appellant had grade modifiers of 1 each for test findings, history, and physical findings, which she added and averaged, finding a grade modifier of 1. The medical adviser noted that there was no adjustment based on functional scale, as she found that the functional scale also equaled a grade modifier of 1 (mild), and therefore appellant had two percent impairment. Regarding appellant's bilateral cubital tunnel syndrome, the medical adviser found under Table 15-23 that appellant had grade modifiers of 1 each for test findings, history, and physical findings, which she added and averaged, finding a grade modifier of 1. She found that the functional scale value was also a grade 1 modifier (mild) resulting in two percent impairment. The medical adviser noted that the second entrapment neuropathy was awarded at 50 percent of the impairment value or one percent.¹⁶ She properly concluded that appellant had a total three percent impairment of each arm.

The Board finds that OWCP medical adviser's opinion, which is based on Dr. Thompson's findings, represents the weight of the evidence and establishes that appellant has no more than 17 percent impairment of the right upper extremity and 11 percent impairment of the left upper extremity that were previously awarded. She properly applied the appropriate provisions of the A.M.A., *Guides* to the clinical findings of record.¹⁷ There is no current medical

¹⁵ See *supra* note 13.

¹⁶ See Example 15-19, page 450, of the sixth edition of the A.M.A., *Guides* entitled Multiple Entrapments.

¹⁷ W.M., Docket No. 11-1156 (issued January 27, 2012).

evidence of record, in conformance with the sixth edition of the A.M.A., *Guides*, showing any greater impairment.

Appellant may request an increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish more than 17 percent impairment of the right upper extremity and 11 percent impairment of the left upper extremity, for which she received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the July 13, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 20, 2016
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board